Documentation Guideline for Nursing Facilities

Kansas Department of Health and Environment
Bureau of Health Facilities
Principles of Documentation

ACKNOWLEDGMENT

This guideline is the result of over a year of work involving staff from nursing facilities, consultants to nursing facilities and staff from the Bureau of Health Facilities. The intent of the guideline is to provide nursing facilities information concerning the regulations governing clinical documentation as well as sharing good practices developed by the provider community in Kansas.

It must be emphasized that guidelines are not regulations. Guidelines assist providers in evaluating and selecting approaches to regulatory issues. Each facility is unique and therefore should develop a documentation system which serves the needs of their staff and their residents. The task force members identified that duplication of entries and the proliferation of forms has increased the work load of staff in many facilities without improving the manner in which care is documented. It is strongly encouraged that nursing facility staff work closely with their Health Information Management professional in developing a documentation system which is efficient and effective.

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Principles of Documentation

Requirements for documentation are derived from:

1. Statutes
2. Regulations
3. Professional Standards of practice
4. Facility policies and procedures
5. Case law

Documentation provides a system for health care professionals to communicate their observations, decisions, actions and the outcomes of the actions. Documentation:

1. Facilitates communication between caregivers and promotes quality care.
2. Informs all caregivers on an ongoing basis of the resident's health status and the care and services provided by the facility staff.
3. Demonstrates that health care professionals have applied knowledge, skills and judgment according to professional standards in the planning and delivery of care to the resident.

Documentation should clearly describe:

1. Assessment of the resident's health status and situation at admission, periodically during their stay in the facility and at discharge.
2. An interdisciplinary plan of care which reflects the needs identified in the assessment and the goals of the resident and/or the resident's legal representative.
3. The resident's responses to the interventions described in the plan of care.
4. Modifications made in the plan of care when interventions were not effective or no longer needed due a change in the resident's condition.
5. Information reported to a physician or other health care provider and that provider's response.
6. Actions undertaken by members of the health care team to advocate on behalf of the resident, including refusal of treatment.
7. Health tracking provided to resident/legal representative/family.

Residents who are clinically unstable, at high risk for a health problem or who have complex health problems generally require more comprehensive, in depth and frequent documentation. Facilities should refer to the guideline for notifying physicians of clinical problems was published in the October 1998 FACT SHEET for guidance in documenting changes in condition.

Activity services and social services provided to groups of residents should be documented, but information about individual residents, including their names, should only be documented in the individual resident's clinical records.

Each facility should develop a set of policies and procedures for documentation.

Common guidelines for documentation:

1. Write legibly in dark ink.
2. Sign all entries with first initial and last name and title. If using initials, the record must have a system in each resident's chart to identify the care provider. The recommended standard is to have a signature sheet for each month. Some facilities have developed a printed list of names of health care personnel. The personnel signs with form with their first and last name and title and their initial's.
3. Document on appropriate facility forms with each page clearly identifying the resident.
4. Correct errors on a written record by drawing a single line through the error, write "error" and initial and date. Do not use white out, erasers or entries between the lines.
5. Document in chronological order with the correct time and date for each entry. If an entry is missed, document "late entry" with the date and time of the entry. State in the narrative the date and time the event occurred.
6. Do not leave blank lines.
7. Make concise notes of relevant information which reflects the care given and the resident's response to the care.
8. Document concurrently or as close to the time of the event. Documentation of medications administered must be performed at the time of administration. Documentation of medications or treatments after a nurse or medication aide's shift was completed is not an acceptable practice.
9. Record accurate notes and use precise professional language. Do not use general statements such as "slept well."
10. Describe the behavior of a resident. Do not use terms which would "label" the resident. Document objective observations, not subjective opinions.
11. Use only abbreviations approved by facility policy.
12. Document only first-hand knowledge and the care the individual caregiver has provided. If facility policy does not provide for unlicensed staff to document in residents clinical records, record their reports and include their name and status.
13. Do not co sign entries documented by other caregivers. When consultants conduct reviews of entries performed by staff they supervise, they should enter a summary note of their own observations and sign and date the entry.
14. It is not considered good practice to document that an incident report was completed. The clinical record should contain complete information about a variance in care.
15. Policies and procedures to ensure confidentiality of all resident records must be developed and implemented. All staff of the facility should have knowledge of the facility's policies related to confidentiality of resident information.